		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006767

Facility Name: Beulah Land Christian Home

Address: 201 East Falcon Hwy - Box C (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2267 **Fax #** ( )

IDPA ID Number: 37-0841562008

Date of Initial License for Current Owners: 1969

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501c3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2003 to June 30, 2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,168	2,574	2,435	11,177	8
9	SNF/PED					9
10	ICF	1,274	898		2,172	10
11	ICF/DD					11
12	SC		7,770		7,770	12
13	DD 16 OR LESS					13
14	TOTALS	7,442	11,242	2,435	21,119	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.15%

D. How many bed-hold days during this year were paid by Public Aid? 364 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 43 and days of care provided 2,435

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	132,764	9,954	6,461	149,179		149,179		149,179			1
2	Food Purchase		107,164		107,164		107,164	(2,470)	104,694			2
3	Housekeeping	91,308		18,463	109,771		109,771		109,771			3
4	Laundry											4
5	Heat and Other Utilities			70,973	70,973		70,973	(4,601)	66,372			5
6	Maintenance	31,778	6,685	19,563	58,026		58,026	5,541	63,567			6
7	Other (specify):*											7
8	**TOTAL General Services**	255,850	123,803	115,460	495,113		495,113	(1,530)	493,583			8
	B. Health Care and Programs											
9	Medical Director			800	800		800		800			9
10	Nursing and Medical Records	672,251	119,317	219,627	1,011,195		1,011,195		1,011,195			10
10a	Therapy			172,332	172,332		172,332		172,332			10a
11	Activities	15,269			15,269		15,269	(829)	14,440			11
12	Social Services	53,938	900	6,043	60,881		60,881		60,881			12
13	Nurse Aide Training											13
14	Program Transportation			72	72		72		72			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	741,458	120,217	398,874	1,260,549		1,260,549	(829)	1,259,720			16
	C. General Administration											
17	Administrative	60,846	715	122,748	184,309		184,309	(85,149)	99,160			17
18	Directors Fees											18
19	Professional Services			2,354	2,354		2,354	4,503	6,857			19
20	Dues, Fees, Subscriptions & Promotions			29,958	29,958		29,958	(16,252)	13,706			20
21	Clerical & General Office Expenses	22,790	4,580	127,171	154,541		154,541	117,317	271,858			21
22	Employee Benefits & Payroll Taxes			216,933	216,933		216,933	14,649	231,582			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,583	9,583		9,583	6,144	15,727			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,448	57,448		57,448	595	58,043			26
27	Other (specify):*											27
28	**TOTAL General Administration**	83,636	5,295	566,195	655,126		655,126	41,807	696,933			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,080,944	249,315	1,080,529	2,410,788		2,410,788	39,448	2,450,236			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Beulah Land Christian Home #0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			122,682	122,682		122,682	8,952	131,634			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,936	34,936		34,936	(1,271)	33,665			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			157,618	157,618		157,618	7,681	165,299			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,735	2,735		2,735		2,735			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,608	23,608		23,608		23,608			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			26,343	26,343		26,343		26,343			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,080,944	249,315	1,264,490	2,594,749		2,594,749	47,129	2,641,878			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,020)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,199)	5		5
6	Rented Facility Space	(3,500)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(23,563)	32		10
11	Discounts, Allowances, Rebates & Refunds	(207)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	80,399	21		24
25	Fund Raising, Advertising and Promotional	(501)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(5,855)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 38,554		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	8,575		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 8,575		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 47,129		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Beulah Land Christian Home

ID# 0006767

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (450)	2	1
2	Activity	(829)	11	2
3	Miscellaneous	(57)	21	3
4	Exempt Interest Income - Endowment	22,292	32	4
5	Loss on Disposal	(11,060)	21	5
6	Marketing Expense	(15,751)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,855)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,470)	0	0	0	0	0	0	0	0	0	0	(2,470)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(9,699)	5,098	0	0	0	0	0	0	0	0	0	(4,601)	5
6	Maintenance	0	5,541	0	0	0	0	0	0	0	0	0	5,541	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,169)	10,639	0	0	0	0	0	0	0	0	0	(1,530)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(829)	0	0	0	0	0	0	0	0	0	0	(829)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(829)	0	0	0	0	0	0	0	0	0	0	(829)	16
	C. General Administration													
17	Administrative	0	(85,149)	0	0	0	0	0	0	0	0	0	(85,149)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,503	0	0	0	0	0	0	0	0	0	4,503	19
20	Fees, Subscriptions & Promotions	(16,252)	0	0	0	0	0	0	0	0	0	0	(16,252)	20
21	Clerical & General Office Expenses	69,075	48,242	0	0	0	0	0	0	0	0	0	117,317	21
22	Employee Benefits & Payroll Taxes	0	14,649	0	0	0	0	0	0	0	0	0	14,649	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,144	0	0	0	0	0	0	0	0	0	6,144	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	595	0	0	0	0	0	0	0	0	0	595	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	52,823	(11,016)	0	0	0	0	0	0	0	0	0	41,807	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	39,825	(377)	0	0	0	0	0	0	0	0	0	39,448	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	8,952	0	0	0	0	0	0	0	0	0	8,952	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,271)	0	0	0	0	0	0	0	0	0	0	(1,271)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,271)	8,952	0	0	0	0	0	0	0	0	0	7,681	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	38,554	8,575	0	0	0	0	0	0	0	0	0	47,129	45

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		5	Utilities	$	Christian Homes, Inc.	100.00%	$ 5,098	$ 5,098	1
2	V		6	Maintenance				5,541	5,541	2
3	V		17	Administrative	122,748			37,599	(85,149)	3
4	V		19	Professional Services				4,503	4,503	4
5	V		21	Clerical				48,242	48,242	5
6	V		22	Employee Benefits				14,649	14,649	6
7	V		24	Travel & Seminar				6,144	6,144	7
8	V		26	Insurance				595	595	8
9	V		30	Depreciation				8,952	8,952	9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 122,748			$ 131,323	$ * 8,575	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: ne 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1996-A GR Bonds	x		Operations		07/01/96	$ 225,000	$ 194,475	07/01/21	0.0700	$ 13,751	1
2	1998-C GR Bonds	x		Operations		11/01/98	480,060	58,979	01/05/05	0.0700	6,501	2
3	2001-X GR Bonds	x		Operations		10/01/01	200,000	200,000	10/01/31	0.0700	14,000	3
4	Bond Financing Fee										684	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 905,060	$ 453,454			$ 34,936	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 905,060	$ 453,454			$ 34,936	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beulah Land Christian Home COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0006767

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-13-27-226-004	S27 T28 R3	$ 85.82	$
2.	13-13-27-203-001	S27 T28 R3	$ 255.94	$
3.	13-13-27-201-012	S27 T28 R3	$ 971.38	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,313.14	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,000	Various	$ 19,470	1
2	Home Office			3,874	2
3	TOTALS	16,000		$ 23,344	3

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1982	1982	$ 1,279,926	$ 31,998	40	$ 31,998	$	$ 705,289	4
5	32		1974	1974	417,998	8,360	50	8,360		281,337	5
6											6
7											7
8	Home Office Allocation				30,818	893		893		15,006	8
	Improvement Type**										
9	Land Improvement			1977	7,756	155	50	155		4,264	9
10	Insulated Windows			1979	16,273	370	44	370		9,127	10
11	Blank										11
12	Ceiling Replaced			1981	1,118	26	43	26		624	12
13	Heating & A/C			1982	25,614		20			25,614	13
14	Bldg Improvement			1982	28,428	711	40	711		15,672	14
15	Bldg Improvement			1982	7,375	184	40	184		4,018	15
16	Bldg Improvement			1982	36,352	909	40	909		19,616	16
17	Insulation			1983	4,400	147	30	147		3,160	17
18	Improvements			1983	2,925	98	30	98		2,075	18
19	Hot Water System			1985	1,577	79	20	79		1,534	19
20	Edge Protectors, Etc			1985	507		15			507	20
21	Light Fixtures			1985	406		15			406	21
22	Garage Work			1985	23,170		15			23,170	22
23	Ceiling Tiles			1985	225		15			225	23
24	Bldg Improvement			1986	36,762	919	40	919		17,002	24
25	Light Fixtures - 1/2			1987	610		10			610	25
26	Window 1/2			1987	840	42	20	42		721	26
27	Blank										27
28	Hot Water System 1/2			1988	979	49	20	49		800	28
29	Chg Water Piping 1/2			1988	390	20	20	20		327	29
30	Water Heater Consult			1988	961		15			961	30
31	Door Alarm System			1988	1,900	95	20	95		1,504	31
32	Vinyl Siding			1988	3,410	171	20	171		2,693	32
33	Carpeting			1989	860					860	33
34	Door Monitor Panel			1989	1,980		10			1,980	34
35	Compressors (2)			1989	924		10			924	35
36	Compressors			9/12/1989	2,306		10			2,306	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Blank		$	$		$	$	$	37
38	Compressor (1)	1989	693		10			693	38
39	Emerg Power Kitchen Light	1990	329		5			329	39
40	Lavatories/Faucets	1990	1,679		5			1,679	40
41	Carpeting	1990	300		5			300	41
42	Compressor	1991	1,828		10			1,828	42
43	Roof Repair	1991	2,340		6			2,340	43
44	Insulating Glass	1991	2,256	68	33	68		861	44
45	Blank								45
46	Door Monitor	1992	1,440		10			1,440	46
47	Room Windows (3)	1992	2,696	135	20	135		1,586	47
48	A/C Units (5)	1992	5,859		8			5,859	48
49	Blank								49
50	Sinks/Faucets	1993	537		5			537	50
51	Door Monitor	1993	1,700		10			1,700	51
52	Mix Valve/Faucet	1993	2,953		10			2,953	52
53	Auto Sprinkler	1993	580	10	10	10		580	53
54	Door Access System	1993	602	22	10	22		602	54
55	Wallcoverings	1993	5,315		5			5,315	55
56	Carpet/Wallpaper	1993	9,540		5			9,540	56
57	Drapes	1994	4,878		10			4,878	57
58	Roofing Project Shelter	1994	62,189	4,146	15	4,146		41,460	58
59	Install Carrier Furnace	1994	1,877	188	10	188		1,864	59
60	Disposer	1994	1,475	12	10	12		1,295	60
61	Nurse Call System	1995	1,040	69	15	69		644	61
62	Upstairs Lib/Comp Room	1995	1,743	174	10	174		1,626	62
63	Garage Doors	1995	676		5			676	63
64	Wanderguard	1995	4,094	409	10	409		3,715	64
65	Blank								65
66	A/C Heating Units	1995	2,326		8			2,326	66
67	Blank								67
68	Heating/AC Units	1995	4,652	93	8	93		4,652	68
69	Carrier Central A/C	1995	2,748	275	10	275		2,406	69
70	TOTAL (lines 4 thru 69)		$ 2,065,135	$ 50,827		$ 50,827	$	$ 1,246,016	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,065,135	$ 50,827		$ 50,827	$	$ 1,246,016	1
2	Heating/AC Units	1995	2,326	95	8	95		2,326	2
3	Water Heater	1996	6,263	626	10	626		5,269	3
4	200 Gallon Storage Tank	1996	4,115	412	10	412		3,433	4
5	Remodel Nursing Wing	1996	3,249		5			3,249	5
6	Heating/AC Units	1996	5,235	654	8	654		5,014	6
7	Mixer/Amp	1997	975	98	10	98		702	7
8	Water Heater	1997	13,453	1,345	10	1,345		9,527	8
9	Eyewash Station	1997	555		5			555	9
10	Exit Lights	1997	1,102	110	10	110		752	10
11	Energy Management System	1997	14,670	551	20	551		4,772	11
12	York C/A Unit	1997	7,839	784	10	784		5,292	12
13	Floor Covering	1997	1,856		5			1,856	13
14	Wall Covering Sit & Bath	1998	2,574		5			2,574	14
15	Floor Covering - Sit & Bath	1998	1,145		5			1,145	15
16	Carpeting	1998	8,739		5			8,739	16
17	Wallpaper	1998	7,497	2	5	2		7,497	17
18	Room Signs	1998	2,270	189	5	189		2,270	18
19	Paint/Wallpaper/Carpet	1999	17,404	1,740	10	1,740		9,570	19
20	Remodel Nurses Station	1999	2,700	180	15	180		930	20
21	Floor Tile/Cove Base	2000	1,144	229	5	229		1,107	21
22	Carpet/Cove Base 2 Rooms	2000	576	115	5	115		546	22
23	A/C Grill Covers (13)	2000	546	109	5	109		509	23
24	Shelter Care Hallway CA	2000	3,686	737	5	737		3,439	24
25	Floor Covering	2000	1,040	208	5	208		953	25
26	Fire Alarm System	2000	32,965	3,297	10	3,297		14,562	26
27	Floor Tile/Cove Base	2000	1,755	351	5	351		1,550	27
28	Remodel - Chapel/Act/Bs/Dr	2000	10,705	1,071	10	1,071		4,463	28
29	AC HEATING UNIT INSTALLED	2000	505	34	15	34		125	29
30	FLOOR COVERINGS	2000	1,143	229	5	229		821	30
31	ENTRY SYSTEM KEYPAD/ALZ. WING	2001	775	155	5	155		478	31
32	DOOR ALARM SYSTEM	2001	1,155	116	10	116		358	32
33	Mixing Valve Installation	2001	1,649	165	10	165		495	33
34	TOTAL (lines 1 thru 33)		$ 2,226,746	$ 64,429		$ 64,429	$	$ 1,350,894	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,226,746	$ 64,429		$ 64,429	$	$ 1,350,894	1
2	Canopy over patio area	2001	6,612	661	10	661		1,818	2
3	Steel Door/East Side of Kitchen	2001	1,393	139	10	139		359	3
4	Floor Coverings - Rooms 404 & 417	9/27/2002	886	177	5	177		325	4
5	(2) Thru Wall Unit A/C	10/18/2002	1,348	169	8	169		296	5
6	Carrier thru-wall HTG/AC unit	3/27/2003	625	42	15	42		56	6
7	80' Red Oak Handrail & Installation	4/21/2003	2,160	144	15	144		180	7
8	Apartment Conversion	2/1/2003	31,913	2,128	15	2,128		3,015	8
9	Railing - Asst Living Loft Area	4/25/2003	3,456	346	10	346		433	9
10	Wiring run for Steamer & Steam Table	4/4/2003	1,644	82	20	82		103	10
11	Tile Bathrooms - Rooms 414/417/423-Carpet 423	5/30/2003	817	163	5	163		190	11
12	Compressor for Laundry A/C	7/21/2003	767	256	3	256		256	12
13	Roof Replacement	9/3/2003	31,762	1,588	15	1,588		1,588	13
14	Add Sprinkler in Mechanical Room	9/26/2003	535	89	5	89		89	14
15	High Efficiency Ballasts/Lights	11/11/2003	12,351	823	10	823		823	15
16	Explosion Proof Light in O2 Room	12/9/2003	1,250	146	5	146		146	16
17	Upgrade Energy Management System	3/2/2004	6,000	143	14	143		143	17
18	Addition to Fire Ext System	4/8/2004	1,338	34	10	34		34	18
19	Install Fire Wall in A/L Dining Room	5/20/2004	2,855	95	5	95		95	19
20	Fully depreciated land improvements	6/30/1974	100,657		20			100,657	20
21	Water & sewer line	11/30/1980	12,325	411	30	411		9,468	21
22	Parking lot lighting	10/31/1983	3,642	47	20	47		3,642	22
23	Sidewalk	11/30/1987	10,600	424	25	424		7,067	23
24	New sidewalk & move fire hydrant	12/12/1989	1,725	78	20	78		1,410	24
25	Outside lights	1/5/1994	2,099	104	10	104		2,099	25
26	Landscaping	6/30/1995	8,515	852	10	852		7,816	26
27	Concrete pad	6/5/1998	3,571	357	10	357		2,172	27
28	Landscaping	8/13/1998	578	8	5	8		578	28
29	Patio	11/17/2000	4,090	409	10	409		1,500	29
30	Landscaping	6/30/2001	1,975	395	5	395		1,218	30
31	Landscaping and fence	10/25/2001	16,799	1,680	10	1,680		4,788	31
32	Repair & Seal Parking Lot	7/25/2003	3,097	1,032	3	1,032		1,032	32
33	Less: Disposals	6/30/2004	(36,791)					(26,713)	33
34	TOTAL (lines 1 thru 33)		$ 2,467,340	$ 77,451		$ 77,451	$	$ 1,477,577	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 262,246	$ 32,727	$ 32,727	$	Various	$ 138,860	71
72	Current Year Purchases	38,840	3,501	3,501		Various	3,501	72
73	Fully Depreciated Assets	225,854				Various	225,854	73
74	Home Office Allocation	49,524	6,595	6,595			6,594	74
75	TOTALS	$ 576,464	$ 42,823	$ 42,823	$		$ 374,809	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Ford Van	2000	$ 47,500	$ 9,896	$ 9,896	$	4	$ 47,500	76
77										77
78										78
79	Home Office Allocation			6,010	1,464	1,464			3,664	79
80	TOTALS			$ 53,510	$ 11,360	$ 11,360	$		$ 51,164	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,120,658	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 131,634	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,634	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,903,550	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 202,868	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 202,868	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Feasibility Costs	$ 2,985	92
93			93
94			94
95		$ 2,985	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 434,310	$	1
2	Cash-Patient Deposits	4,948		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,619)	37,837		3
4	Supply Inventory (priced at FIFO)	15,331		4
5	Short-Term Investments	24,240		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest & Other A/R	7,563		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 524,229	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	222,338		13
14	Buildings, at Historical Cost	2,284,296		14
15	Leasehold Improvements, at Historical Cost	152,226		15
16	Equipment, at Historical Cost	574,442		16
17	Accumulated Depreciation (book methods)	(1,878,286)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	541,843		21
22	Other Long-Term Assets (spe CIP	2,985		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,899,844	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,424,073	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 67,545	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,948		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,720		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,970		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 153,183	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	453,454		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 453,454	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 606,637	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,817,436	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,424,073	$	48

***(See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,508,213	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,508,213	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	47,223	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 47,223	17
	B. Transfers (Itemize):		
18	**Transfer In from Affiliate**	262,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 262,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,817,436	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,771,755	1
2	Discounts and Allowances for all Levels	(568,053)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,203,702	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	293,160	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 293,160	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	500	13
14	Non-Patient Meals	2,020	14
15	Telephone, Television and Radio	6,199	15
16	Rental of Facility Space	3,500	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,765	19
20	Radiology and X-Ray	207	20
21	Other Medical Services	11,925	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,116	23
	D. Non-Operating Revenue		
24	Contributions	100,284	24
25	Interest and Other Investment Income***	23,563	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 123,847	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investmets; Sales of Equip	(8,853)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (8,853)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,641,972	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	495,113	31
32	Health Care	1,260,549	32
33	General Administration	655,126	33
	B. Capital Expense		
34	Ownership	157,618	34
	C. Ancillary Expense		
35	Special Cost Centers	2,735	35
36	Provider Participation Fee	23,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,594,749	40
41	**Income before Income Taxes (line 30 minus line 40)****	47,223	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 47,223	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,043	1,050	$ 30,724	$ 29.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,304	5,336	125,116	23.45	3
4	Licensed Practical Nurses	4,667	4,755	94,919	19.96	4
5	Nurse Aides & Orderlies	32,081	32,467	405,469	12.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,500	1,516	16,023	10.57	8
9	Activity Director					9
10	Activity Assistants	1,560	1,565	15,269	9.76	10
11	Social Service Workers	3,473	3,490	53,938	15.46	11
12	Dietician					12
13	Food Service Supervisor	1,696	1,778	25,695	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,499	11,847	107,069	9.04	15
16	Dishwashers					16
17	Maintenance Workers	1,754	1,812	31,778	17.54	17
18	Housekeepers	10,053	10,325	91,308	8.84	18
19	Laundry					19
20	Administrator	1,857	1,930	60,846	31.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,619	1,645	22,092	13.43	23
24	Clerical	75	76	698	9.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,181	79,592	$ 1,080,944 *	$ 13.58	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	138	$ 6,029	1.3	35
36	Medical Director	60	800	9.3	36
37	Medical Records Consultant	32	1,641	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	600	10.3	39
40	Physical Therapy Consultant	1,373	46,298	10A.3	40
41	Occupational Therapy Consultant	1,191	74,968	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	211	12,231	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	68	5,743	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,169	$ 148,310		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
W Jean Greenley	Administrator	0	$ 60,846
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,846

B. Administrative - Other

Description	Amount
Management Expense	$ 122,748
TOTAL (agree to Schedule V, line 17, col. 3)	$ 122,748
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 151
Charles Butzow	Architect	618
Davis & Campbell	Legal	1,585
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,354

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,876
Unemployment Compensation Insurance	3,600
FICA Taxes	79,947
Employee Health Insurance	78,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
W C Medical Expense	54
Employee Expense	10,012
Employee Physicals	1,741
Employee Uniforms	703
Home Office Allocation	14,649
TOTAL (agree to Schedule V, line 22, col.8)	$ 231,582

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,500
Advertising: Employee Recruitment	2,130
Health Care Worker Background Check	
(Indicate # of checks performed)	
Software Support & Maint Fees	5,962
IHCA Dues	2,025
Dues & Miscellaneous Fees	943
Subscriptions	545
Life Services Network	601
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,706

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,988
Seminar Expense	4,595
Home Office Allocation	6,144
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,727

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Beulah Land Christian Home **#** 0006767 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $ 2025**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **0**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **0**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,434** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **23,608**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,020**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

Beulah Land Christian Home
Allocation on Benefits 6/30/2004 sms
11/2/2005

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Worker's Comp Med Exp.	Employee Uniforms	Employee Expense	Employee Physicals		
5,701.85	192.00	2,256.00	6,400.00	10.71	702.72	10,012.38	1,741.00	27,016.66	
2,379.00	84.00	936.00	4,800.00	44.00				8,243.00	
9,895.31	468.00	5,604.00	6,000.00					21,967.31	
6,684.89	360.00	4,440.00	4,800.00					16,284.89	
50,088.25	2,244.00	26,688.00	46,400.00					125,420.25	
5,197.32	252.00	2,952.00	9,600.00					18,001.32	216,933.43
79,946.62	3,600.00	42,876.00	78,000.00	54.71	702.72	10,012.38	1,741.00	216,933.43	

Line 3.22.3 216,933.43

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Beulah Land Christian Home
Staffiing and Salary Costs

			06/30/04		sms 11/02/05	LMCV
Description	**Line Number**	**Salary**	**% of Benefits**	**Benefits**	**Total Salary**	
Director of Nursing	20.1	29,830.02	4.57%	894.40	30,724.42	
Assist. DON	20.2	0.00	0.00%	0.00	0.00	
Registered Nurses	20.3	121,474.17	18.61%	3,642.17	125,116.34	
Licensed Practical Nurses	20.4	92,155.58	14.12%	2,763.11	94,918.69	
Nurses Aides & Orderlies	20.5	393,665.20	60.32%	11,803.30	405,468.50	
Rehab/Therapy Aides	20.8	15,556.87	2.38%	466.44	16,023.31	
	Total	652,681.84	100.00%	19,569.42	672,251.26	

	Benefits	19,569.42				
	20.1	20.2	20.3	20.4	20.5	20.8
	29,830.02		898.37	810.07	5,401.84	15,556.87
			108,811.25	42,129.84	2,165.23	
			11,764.55	41,319.00	2,185.07	
				7,209.97	352,931.43	
				686.70	14,049.80	
					13,766.31	
					418.65	
					2,746.87	
Totals	29,830.02	0.00	121,474.17	92,155.58	393,665.20	15,556.87

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